

THE THIRD NATIONAL AIDS MALIGNANCY CONFERENCE

SPONSORED BY THE NATIONAL CANCER INSTITUTE

May 26-27, 1999

Natcher Conference Center
National Institutes of Health
45 Center Drive
Bethesda, Maryland

REGISTRATION FORM

Please type or print clearly.

_____ ☐ Male ☐ Female
Last Name First Name, Middle Initial

Title_____ Degrees ☐ M.D. ☐ Ph.D. ☐ Other_____ Specify

Affiliation_____

Mailing Address_____

City_____ State/Province_____ Country_____

Postal/Zip Code_____ Daytime Telephone_____ Telefax_____

(Please Be Sure to Include Country/City Code)

E-mail:_____

Major Interests (Check All That Apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Clinical Oncology | <input type="checkbox"/> Clinical Trials | <input type="checkbox"/> Pharmacology |
| <input type="checkbox"/> Clinical Hematology | <input type="checkbox"/> Epidemiology | <input type="checkbox"/> Virology Research |
| <input type="checkbox"/> Clinical Infectious Diseases | <input type="checkbox"/> Immunology Research | <input type="checkbox"/> Other Sciences |
| <input type="checkbox"/> Clinical Pathology | <input type="checkbox"/> Pathology Research | <input type="checkbox"/> Other_____ |

Early Registration: April 26, 1999

Before/On April 26, 1999 _____
Conference Fee (\$100.00) *

After April 26, 1999 _____
Conference Fee (\$175.00) *

Seating is limited, please register early.

* Fee waived for NIH employees

Enclosed:

☐ Check Amount_____

☐ Money Order Amount_____

☐ Purchase Order Number_____

Organization_____

Please attach a copy of your purchase order.
Credit cards cannot be accepted.

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NOTE: *Continuing Medical Education (CME) credit will be available. We will advise you as to the category and number of credit hours available for your participation in the meeting.*